CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
1000 SW JACKSON, SUITE 220
TOPEKA, KANSAS 66612-1274
(785) 296-1313 OR (TOLL FREE) 1-800-332-6262

CYSHCN Patient's Name:_____

Date of Birth:_____

On _____ the above name patient was:

( ) Seen in doctor's office ( ) Attended clinic
( ) Admitted to hospital ( ) Other_____

_____
(Signature of physician or designee)
**If designee signs, please include physician's name**

Round trip **From** (CITY)
**To** (CITY)

Please send reimbursement for mileage as authorized to:

NAME:

Social Security Number*_____

ADDRESS: (STREET)
(CITY) (ZIP)

*SOCIAL SECURITY NUMBER IS REQUIRED FOR THE PERSON BEING REIMBURSED.

***PLEASE NOTE:*** ***Request for reimbursement must be received in the CYSHCN office within six months of date of travel.***

**PLEASE DO NOT WRITE BELOW THIS LINE.**
FOR OFFICE USE ONLY.

_____ miles @ **$.22** per mile

Total amount **$**

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